ERGO Life Insurance SE

Health Insurance rules No. 010

Approved by ERGO Life Insurance SE CEO's Order No SE 53/v of 29 December 2014.
Effective from 1 January 2015.

1. Definitions Used in the Rules

1.1. **"Insurer"** means ERGO Life Insurance SE.

1.2. **"Insurance contract"** means a health insurance contract concluded between the insurer and a policyholder.

1.3. **"Policyholder"** means a natural person of full age or a legal person who has concluded an insurance contract with the insurer and must pay insurance premiums.

1.4. **"Parties of an insurance contract"** means the insurer and a policyholder.

1.5. **"Insured person"** means a person specified by a policyholder and nominated in an insurance contract to whom, upon occurrence of an insured event in his life, the insurer must pay an insurance benefit. Several persons may be insured under one insurance contract.

1.6. **"Insurance cover"** means the insurer's commitment to pay an insurance benefit upon occurrence of an insured event

1.7. **"Beneficiary"** means the person specified in the insurance contract, entitled to the insurance benefit in the cases specified in the insurance contract. A policyholder may appoint and change persons entitled to the insurance benefit under the insurance contract. In the cases specified in the laws, beneficiaries may be appointed or changed only with the consent of an insured person.

1.8. **"Insurance benefit"** means an amount of money which the insurer must pay under the insurance contract conditions to the insured person and/or to the health care institution for health care services provided to the insured person in relation to an insured event.

1.9. **"Health care institution"** means an institution or a company which is entitled to provide with health care, wellness and pharmaceutical services according to the procedures set out in the laws of the Republic of Lithuania.

1.10. **"Health care services"** means qualified personal health, wellness and pharmaceutical services provided at a health care institution.

1.11. **"Service provider"** means an institution or a company which is entitled to provide with health care, wellness, health promotion and pharmaceutical services and aid according to the procedures set out in the laws of the Republic of Lithuania, which the insurer has concluded a cooperation (service) contract with for providing of health care services to the insured persons.

1.12. **"Health Insurance book (card)"** means a book (card) of the form established by the insurer issued to each insured person, indicating the list of health care services which the insurer compensates to the insured person and the sum insured.

1.13. **"Health disorder"** means change of the health or physiological condition of an insured person (in the case of acute diseases, exacerbation of a chronic disease and/or trauma) which requires application of medically-based treatment, diagnostic, prophylactic or wellness measures and other health care services.

1.14. **"Treatment"** means physician's consultations, medical treatment, medicines used to treat or prevent a disease.

Other terms used in these insurance rules are interpreted as they have been defined in the Law on Insurance of the Republic of Lithuania and other legal acts of the Republic of Lithuania.

2. Conclusion of an Insurance Contract

2.1. A policyholder, in order to conclude an insurance contract, shall submit to the insurer the application of the form established by the insurer and the list of insured persons. The policyholder's application and the list of insured persons, together with these insurance rules, shall become an integral part of the insurance contract when the latter is concluded.

2.2. The insurer, after assessing the insurance risk, may refuse to conclude an insurance contract without giving any reasons. Submission of an application and payment of a premium does not obligate the insurer to conclude an insurance contract. If the insurance premium has been paid pursuant to a submitted application prior to the insurance risk assessment and the insurer's refusal to conclude an insurance contract, the premium is returned to the person who paid it. If during this period an insured event specified in these insurance rules occurs, the insurer is not required to pay the insurance benefit.

2.3. If the insurer agrees to conclude an insurance contract, an insurance policy shall be issued to the policyholder certifying the conclusion of the insurance contract. The insurance contract date is the insurance policy issuing date.

2.4. The insurance contract may be concluded by setting individual insurance conditions, if the insurer and the policyholder agree separately upon such conditions.

3. Insured Event

3.1. Insured event means an event specified in the insurance contract upon occurrence of which the insurer must pay the insurance benefit.

3.2. The event shall be recognized as the insured event only if the physician providing services acts within the competence limits of the physician's specialty described and approved by applicable legal acts and holds a valid licence of medical practice issued by a competent state authority.

3.3. The description of insured events is provided in Annex 1 to these insurance rules.

3.4. If treatment of an insured person is continued for a disease or accident which has no causal relation to health disorder treated up to now, it shall be assessed as a separate insured event.

4. Non-insured Events

4.1. Non-insured events are the events, where the insurer is not under an obligation to pay insurance benefits (unless agreed otherwise in the insurance contract).

4.2. The insurer shall not pay any insurance benefits:

4.2.1. for health care services, treatment and/or other services provided in relation to:

a) health disorders that were caused when the insured person injured himself intentionally or by gross negligence, or attempted to commit suicide. Gross negligence shall be deemed failure to comply with simple rules of conduct understandable to everyone or ignoring and/or failure to comply with the requirements of safe behaviour certainly known to the person;

b) health disorders resulting from committing a criminal offence or preparation to commit it and/or committing other acts contrary to the law by the insured person. Indications of a criminal offence or preparations to commit it or other acts or omissions contrary to the law are proven and the insurer may substantiate his decision to recognise the event a non-insured event by the following: conclusions, procedural decisions of pre-trial investigating authorities and bodies authorized to hear administrative cases and/or court judgments, decisions, resolutions and rulings;

c) health disorders resulting from the effect of pandemics, natural disasters (such as violent storms, cyclones, earthquakes, tides and floods, lightning), any form of war, military actions (regardless of whether war was declared or not), the state of national emergency, insurrection, riot, internal unrest which reaches the level of use of military or illegal force by participation in acts of violence

d) health disorders which occurred through the fault of the policyholder or the beneficiary (offences committed with a specific or general intent); a specific intent - a person performing certain actions understood their dangerous nature to health and wanted to act in that way; general intent - a person performing certain actions understood their dangerous nature (in this case to health), envisaged that his actions may have negative consequences (to health) and although he did not want them, but deliberately allowed them to occur;

e) health disorders resulting from exposure to radiation or other effects of nuclear power (excluding the consequences of radiation therapy);

f) health disorders resulting from the effect of alcohol, drugs or toxic substances used by the insured for intoxication purposes, or medicines that were not prescribed by a physician;

g) health disorders which occur during the time period, when insurance cover is not effective (suspension).

4.2.2. for the provision of health care services, treatment and/or other services:

a) pregnancy care, childbirth and postpartum care, treatment of health disorders resulting from pregnancy or childbirth, if the insurance contract does not provide otherwise;

b) surgical treatment of congenital diseases, abnormalities and their complications;

c) treatment of persons ill with dependence on psychoactive substances (tobacco, drugs, alcohol, psychotropic substances) diseases;

č) undertaking activities unlicensed by the Ministry of Health of the Republic of Lithuania and/or using non-approved diagnostic and treatment methods, services;

d) psychotherapeutic treatment continuing more than 10 sessions;

e) diagnosis and treatment of sexually transmitted diseases (syphilis, gonorrhoea, trichomoniasis, chlamydia, human papilloma virus, herpes genitalis, etc.), genital warts, AIDS and HIV;

ė) diagnosis and treatment of impotence and infertility, in vitro fertilization;

f) termination of pregnancy in the absence of medical indications and childbirth outside a medical facility;

g) advice on family planning, contraception; insertion, control or removal of contraceptives; diagnostic tests prior to the prescription of contraceptives and tests intended to avoid complications due to consumption of these measures;

h) cosmetic-plastic surgery, cosmetic/beauty treatments (aesthetic, development of body lines, anti-cellulite, body scrub, wrapping etc.), as well as the use of functional, diagnostic equipment, devices and instruments directly related to these treatments;

i) organ transplant operations; bone marrow transplantation, haemodialysis procedures;

y) supportive treatment and nursing care in specialized inpatient institutions (permanent, long-term care for the elderly, disabled people and patients with chronic diseases, including services at home, nursing care institutions, medical centres, social welfare institutions);

j) therapeutic and surgical treatment of obesity;

k) treatment of warts and moles, skin benign derivatives, vascular lesions, spots, pigmentation disorders (unless the contract provides otherwise);

l) intervention therapy (sclerotherapy) of vein/capillary diseases and surgical treatment of varicose veins (unless the contract provides otherwise);

m) surgical treatment of benign tumours;

n) vision correction, joint replacement surgery;

o) health care services and/or treatment performed by the insured person's spouse, parents or children;

p) provided and/or carried out during the insurance cover ineffectiveness (suspension) time period;

r) health care services, not included in the insurance contract;

s) where the insured has exceeded the limits of sum insured for health care services of the insurance option set out in the insurance contract;

š) purchase of medicines: anabolic steroids, weight-reducing, increasing potency, contraceptives, for treatment of various addictions, for treatment of diseases and disorders specified in items (e) and (ė) of paragraph 4.2.2, medicines unregistered by State Medicines Control Agencies in Lithuania and European Union countries; food supplements (unless the contract provides otherwise); hygiene and cosmetic means;

t) purchase of medical supplies, medical devices, first aid means, diagnostic and therapeutic devices (thermometers, inhalers, testers, warmers, hearing aids, scales and blood pressure measuring devices, glucometers etc.); biochemical diagnostic kits;

u) purchase of eyeglass frames, goggles and sunglasses, contact lenses and eyeglass lens care products, eyeglass manufacturing services (unless the contract provides otherwise);

ū) health care services and/or treatment, the dates and circumstances of which may not be detected during investigation of the event;

v) when appointment of diagnostic tests and treatment to the insured person is are not medically substantiated;

z) where the insurance cover provided in the insurance contract is used not by the insured person;

ž) purchasing of medicines, medical instruments, orthopaedic products and providing of health care services under prescription or referral issued by the insured person himself.

4.2.3. The insurer shall not pay the costs related to issuing and/or submission of medical and other documents.

5. Insurance Object and Insurance Cover

5.1. Insurance object means property interests related to a person's health provided with insurance cover according to these insurance rules.

5.2. The beginning, the end and the scope of insurance cover is specified in the insurance policy, the individual terms of insurance, other agreements between the parties of the insurance contract (insurance contract annexes), in these insurance rules.

6. Sum Insured

6.1. Sum insured means the sum of money specified in the insurance contract per one insured person, within which the insurer undertakes to pay to the insured person or the health care institution for health care services provided to the insured person upon occurrence of an insured event according to the scope of insurance cover specified in the insurance contract. Sums insured agreed upon between the parties of the insurance contract are specified in the insurance policy.

6.2. The insurance contract can specify sums insured for separate insurance periods and distribute sums insured for specific insurance risk groups.

6.3. Upon payment of the insurance benefit, the insurer's obligation to pay insurance benefits shall continue for the remainder of the sum insured.

7. Insurance Premiums and Procedures of their Payment

7.1. Insurance premium rates are established in accordance with the Republic of Lithuania morbidity indicators. Insurance premium is calculated based on the selected volume of insurance cover, the insured person's gender, age and other risk factors.

7.2. Insurance premium amounts and their payment terms are specified in the insurance policy. Insurance premiums are paid in advance for each period of insurance. A first or a single premium must be paid immediately after concluding of the insurance contract. All other insurance premiums (regular premiums) must be paid within the time limits specified in the insurance policy.

7.3. Insurance premium payment date is deemed the date when the premium is credited to the insurer's bank account. If it is impossible to determine according to the payment order in relation to which insurance contract the insurance premium was paid, the insurance premium payment date will be the date on which the insurer attributes that premium to the relevant insurance contract. If a policyholder pays the premium in cash, the insurance premium payment date shall be the date of the cash receipt, issued by the insurer to confirm acceptance of the money.

7.4. If a policyholder fails to pay a regular insurance premium in the time specified in the insurance contract, the insurer shall notify the policyholder about this in writing at the policyholder's expense. If the policyholder fails to pay the insurance premium within 15 days after the dispatch of notification about the outstanding premium, the insurance cover is suspended and is resumed only after the policyholder pays all premiums that were not paid within the set deadlines.

7.5. If suspension of the insurance cover due to failure to pay an insurance premium lasts for more than 3 months, the insurer has the right to unilaterally terminate the insurance contract. The insurer cancelling the contract for failure to pay premiums shall be entitled to claim from the policyholder compensation for the insurer's damages arising from the failure to pay the insurance premium.

8. Duration of the Insurance Contract

8.1. The insurance period is specified in the insurance policy. The insurance contract shall enter into force if all the following conditions have been met: an insurance certificate has been issued to the policyholder, a first or a single premium has been paid. The insurer has the right to declare the contract in force also in the absence of all the listed conditions.

8.2. The insurance cover is valid subject to payment of a first or a single premium, but not before the insurance contract is concluded, and not before the beginning of insurance referred to in the insurance policy. With the insurer's consent, the insurance cover can begin earlier.

9. Rights and Obligations of the Insurance Contract Parties

9.1. The policyholder entering into the insurance contract shall:

- submit an insurance application of the form established by the insurer, the list of insured persons and other information required by the insurer for concluding the insurance contract;
- provide the insurer with comprehensive, true information about the person to be insured or already insured, health insurance contracts of this person concluded or to be concluded;
- familiarize the insured person with the insurance contract conditions applicable or related to him;
- pay the insurance premiums set out in the insurance contract;
- pay fees for additional services of an insurance contract set out in the insurance contract (Annex 2 to these insurance rules).

9.1. The insurer undertakes to:

a) not to disclose information about a policyholder or an insured person received during conclusion of an insurance contract, except for the cases and/or exceptions provided in the insurance contract or the law;

b) familiarise a policyholder with these insurance rules, insurance premium rates and issue an insurance policy, when an insurance contract is concluded;

c) perform other statutory obligations of the insurer.

9.1. If it is found after concluding an insurance contract that a policyholder or an insured person failed to meet their obligation to disclose information during concluding of an insurance contract or during its validity period, and provided the insurer with incomplete, untrue information about a policyholder, an insured person or the circumstances that may have a material impact on the insurance risk assessment, probability of occurrence of an insured event, for determining of the insurance contract fees, insurance premiums and sum insured, or other significant circumstances of the insurance contract, the insurer has the right to terminate the insurance contract or reduce the insurance benefit or refuse to pay it.

9.2. Any notices related to an insurance contract shall be submitted in writing. Such communications shall be effective to the insurer from the moment of their receipt.

9.3. A policyholder must notify the insurer within five business days about the change of his correspondence address and/or name. Otherwise the policyholder will have to bear the related costs, if a messa-

ge addressed to him is sent by registered mail to the address known to the insurer, when a policyholder fails to inform about the change of the address.

9.4. During an insurance contract period, a policyholder must notify the insurer in writing within five business days about the change of any information about the policyholder or the insured person specified during concluding of the insurance contract.

9.5. The policyholder and/or the insured person must immediately but not later than within seven days notify the insurer about the health insurance book (card) being misused, lost or otherwise vanished.

9.6. If it is found that an insured person or a policyholder transferred a health insurance book (card) to a person who used or attempted to use it, the insurer has the right to refuse to pay the insurance benefit for health care services provided under such circumstances, with a written notice to the policyholder and/or the insured person.

9.7. A policyholder, when the policyholder's employees are insured under the insurance contract, must immediately inform the insurer in writing, if the insured person terminates the employment or other contractual relationship with the policyholder, and return the health insurance book (card) within the time limit set by the insurer.

9.8. A policyholder shall inform the insurer about all health insurance contracts concluded with another insurance company in favour of the insured person or the policyholder within 30 days from the date of concluding the insurance contract with another insurance company.

9.9. The policyholder and/or the insured person must submit to the insurer all documents and information about the circumstances and the consequences of the insured event necessary for the insurer to determine the amount of insurance benefit.

9.10. The insured person must take any available steps to reduce the damage to health and avoid and refrain from any actions which could impair the course of treatment or the insured person's health.

9.11. The insured person may choose any health care institution in Lithuania, which has the right to provide health care services according to the laws of the Republic of Lithuania.

9.12. In order to determine whether insurance benefits shall be paid, the insurer may request from the policyholder, the insured person or other parties additional evidence and information related to the assessment of the insured event, provided health care and other services specified in the insurance contract, determination of the amount of insurance benefit, or perform the necessary investigation at his own expense, or to appoint a medical expert.

9.13. The insurer has the right to unilaterally change the list of service providers, to choose their services, the scope of services, to set the limits to the services.

9.14. If an insurer pays an insurance benefit to the insured person or pays the invoices of health care institutions for the services of health care institutions provided to the insured persons, when the limit of the sums insured for the service was exceeded, or when the insurance cover did not have to be applied to the insured persons, the insurer is entitled to claim from the policyholder or the insured person to reimburse the insurer for the loss related to such benefits, including the amounts of money paid by the insurer to health care institutions and/or the insured person.

9.15. Upon a written request of the policyholder and payment of the additional fee specified in the price list of additional services of the insurance contract (Annex 2 to these insurance rules), a duplicate insurance policy may be issued. Based on the written request of the policyholder, the insurer may provide other additional insurance contract administration services. The policyholder or the insured person must pay the fees established by the insurer for these services.

10. Procedure for Determining of Insurance Benefits

10.1. Insurance benefits are paid within the insurance coverage limits set out in the insurance contract.

10.2. The policyholder or the insured must notify about the insured event in writing immediately, but no later than within 30 calendar days from the date of the event. If an insured person was provided with health care services by a service provider, then the policyholder and/or insured person are exempt from the obligation to inform the insurer about the insured event.

10.3. The insurer shall calculate and pay insurance benefits:

10.3.1. For health care services provided by service providers - according to the rates of service providers;

10.3.2. Outpatient services for health care institutions with which the insurer has no cooperation (services) contracts for providing of health care services to the insured persons shall be paid within four times of base prices for health care services approved by the Ministry of Health.

10.4. The insurer shall pay insurance benefits to service providers upon presentation of documents confirming provision of health care services according to the procedures, scope and rates set out in the cooperation (service) contracts with service providers.

10.5. If the insured person has paid his own money for health care services, the insurer shall pay the insurance benefit to the insured person upon presentation of the following documents or copies thereof:

10.5.1. An invoice with a cash register receipt/payment order or a cash income slip/money receipt, which must have the details (the name, identification number, address) of the service/goods provider, details of the payer (name, surname, personal number) and a detailed description of services/goods (name, quantity, price, date of receipt);

10.5.2. Referral/extract or a copy of medical records containing information about the nature of disease, diagnosis, appointed tests, procedures, treatment;

10.5.3. A prescription or a copy of medical records, which contain information about the nature of disease, diagnosis, prescribed treatment, if medicines, medical instruments, orthopaedic technical products, orthopaedic socks, compensation technical means, optical goods have been purchased;

10.5.4. A completed request for reimbursement of health insurance costs (the standard form of the insurer);

10.5.5. A completed leaflet of the health insurance book, if the book was issued to the insured person.

10.6. The costs related to issuing and submission of the documents confirming provided health care services shall be borne by the person who seeks the insurance benefit.

10.7. If the treatment or appointed diagnostic tests are not medically reasonable, the insurer may refuse to pay the insurance benefit and/or reduce it.

10.8. The insurer may reduce or refuse to pay the insurance benefit, if the policyholder or the insured person has submitted false information or deliberately misleading information about the health care services provided, or if the insured has not complied with the requirements specified in paragraphs 9.3, 9.14 and 10.2.

10.9. If the insured person is insured under several insurance contracts with different insurers, then the insurance benefit payable in case of the insured event shall be reduced proportionately.

10.10. If the insurance benefit has already been paid in relation to the same insured event for the same service or purchased medicine/medical instrument, a repeated insurance premium shall not be paid.

11. Procedure for Payment of Insurance Benefits

11.1. The insurer pays insurance benefits to the health care institution which provided health care services to the insured person, or to the policyholder or the insured person, if he has paid to the health care institution for the health care services provided.

11.2. The insurer shall pay insurance benefits not later than within 30 calendar days from the date of receipt of all information significant

for establishing of the fact, circumstances and consequences of the insured event, and the amount of insurance benefit.

11.3. The insurer has the right to reduce the insurance benefit by the amount of insurance premiums unpaid before the insured event and deduct the amounts related to concluding and execution of the contract unpaid by the policyholder according to the procedure established by the insurer.

12. Termination of an Insurance Contract

12.1. The policyholder has the right to terminate the insurance contract by giving the insurer at least one month written notice before the intended date of the insurance contract termination.

12.2. The insurer may terminate the insurance contract unilaterally out of court in the cases specified in paragraphs 7.5 and 9.3 of these rules.

12.3. When the insurance contract is terminated on the policyholder's initiative without the breach of the insurance contract conditions by the insurer, or on the insurer's initiative due to the breach of the insurance contract conditions by the policyholder, the insurer shall reimburse to the policyholder the portion of the insurance premium for the remaining duration of the insurance cover, after deduction of the insurance contract concluding and execution costs and the amounts paid under that contract. The insurer is entitled to deduct 15% of the annual premium amount as the insurance contract concluding and execution costs.

12.4. When the insurance contract is terminated on the policyholder's initiative due to the breach of the insurance contract conditions by the insurer, the portion of the insurance premium for the remaining duration of the insurance cover after the termination date shall be reimbursed to the policyholder, after deduction of the insurance contract concluding and execution costs, which account for 15% of the estimated annual amount of the insurance premium

13. Amendment of an Insurance Contract

13.1. In order to change the insurance contract, the policyholder shall submit to the insurer in writing (by e-mail/fax/registered mail) the application of the form established by the insurer about the desired changes to the insurance contract not later than one month before the intended date of the amendment of the insurance contract. If the policyholder misses this deadline or does not specify it, the insurance shall amend the insurance contract no later than one month from the date of receipt of the policyholder's application. The insurer, after assessing the changing circumstances, may refuse to amend the insurance contract conditions. The amendments to the insurance contract shall take effect from the date specified in the amendment to the insurance contract or amended insurance policy issued by the insurer.

14. Liability for Violation of the Insurance Rules

14.1. If the policyholder does not pay insurance premiums or other payments under an insurance contract within the prescribed time limit, the policyholder at the insurer's request must pay 0.02% interest on the unpaid amount for each day of delay.

14.2. If the insurer does not pay insurance benefits within the prescribed time limit, at the policyholder's request, he must pay 0.02% interest on the outstanding amount of insurance benefits for each day of delay.

15. Procedure for Assignment of Rights and Obligations under the Insurance Contract

15.1. The insurer on the basis of a written contract and a permit received from the Lithuanian Insurance Supervisory Authority has the right to assign its rights and obligations under the insurance contract to another insurance company, to an insurance company of another EU Member State or the branch of a foreign insurance company established in the Republic of Lithuania or another EU Member State according to the procedures established by the laws of the Republic of Lithuania.

15.2. The insurer's notice of its intention to transfer its rights and obligations under the insurance contract must specify a term of not less than two (2) months, during which the policyholder has the right to express in writing to the insurer its objections regarding the intention to transfer the insurer's rights and obligations under the insurance contract.

15.3. If the policyholder does not agree with assignment of the rights and obligations under the insurance contract, it is entitled to terminate the insurance contract within one month after the assignment of the rights and obligations with the insurance contract termination notice made in writing to the insurer. Upon termination of the insurance contract on the grounds specified in this paragraph, the portion of the insurance premium for the remaining duration of the insurance cover shall be reimbursed to the policyholder, after deduction of the insurance contract concluding and execution costs.

16. Final Provisions

16.1. The insurance contract is governed by the laws of the Republic of Lithuania.

16.2. The disputes arising between the policyholder and the insurer shall be settled out of court, according to the consumers and insurers dispute settlement rules established by the Bank of Lithuania, or at court, according to the laws of the Republic of Lithuania.

16.3. The insurer has the right to amend the insurance rules, which make the basis for the insurance contract, if it does not violate the interests of the policyholder, the insured person and the beneficiary.

16.4. The insurer also has the right to supplement and amend certain paragraphs of the insurance rules, which make the basis for already concluded insurance contracts, in the following cases: amendment or adoption of new laws, which the insurance rules were based on, or amendment of laws directly applicable to the insurance contract, or when an objective necessity occurs due to economic situation (e.g. in the event of hyperinflation). New provisions of the insurance rules shall not worsen the situation of the policyholder and/or insured persons in comparison with the previous version.

16.5. The insurer must inform the policyholder in writing about amendment of the insurance rules specified in paragraphs 16.3 and 16.4. These amendments of the insurance rules shall take effect one month after the date on which the policyholder received notification about amendment of the insurance rules, unless the insurer indicates a different date. If the policyholder does not agree with the amendment of the insurance rules, he may terminate the insurance contract. When an insurance contract is terminated on this basis, provisions of paragraph 12.4 of the rules shall apply to payments.

Dr. Kęstutis Bagdonavičius
Chief Executive Officer

Ingrida Kirse
Member of the Board

Health Insurance rules No. 010 Annex 1

Insured events (Health Insurance programs)

The following insured events (health insurance programs) can be specified in the insurance contract:

1. Outpatient treatment

(excluding outpatient rehabilitation)

- Physician's services;
- Diagnostic tests;
- Day surgery;
- Day-patient services;
- Services of nurses.

2. Inpatient treatment in public medical institutions

(except for rehabilitation treatment)

Additional services in public hospitals:

- Single or double ward;
- Services of nurses;
- Surcharges for medical and nursing instruments;
- Surcharges for medicines.

3. Inpatient treatment in public and private medical institutions

(except for rehabilitation treatment)

Additional and medical services in public/private hospital:

- Single or double ward;
- Specialist physicians' services;
- Diagnostic tests;
- Services of nurses;
- Medical and nursing instruments;
- Medicines;
- Surgical treatment.

4. Medicines, medical instruments and orthopaedic technical products

- Medicines;
- Medical instruments and orthopaedic technical products.

5. Non-prescription medicines, dietary supplements and vitamins

- Non-prescription medicines;
- Dietary supplements;
- Vitamins.

6. Rehabilitation treatment

- Kinesitherapist's, ergotherapist's, speech therapist's consultations;
- Physiotherapy treatments;
- Kinesitherapy sessions;
- Water and mud treatments;
- Manual therapy sessions;
- Massages.

7. Rehabilitation treatment after hospital treatment

- Kinesitherapist's, ergotherapist's, speech therapist's consultations;
- Physiotherapy treatments;
- Kinesitherapy sessions;
- Water and mud treatments;
- Manual therapy sessions;
- Massages.

8. Rehabilitation treatment after hospital treatment

Dental treatment and oral hygiene services:

- Dentist's, dental hygienist's consultations;
- Removal of dental concretions, plaque cleaning;
- Fluorine applications;
- Endodontic, periodontal, therapeutic and surgical treatment of tooth diseases, anaesthesia, X-ray examination.

Dental prosthetics service (optional clause):

- Dentist's consultations on the prosthetic/ implantation, orthodontic treatment;
- Production, restoration and repair of removable and non-removable dentures;
- Implantation of teeth, dental implants, orthodontic treatment, braces.

9. Preventive health examination

- Mandatory health examination;
- Tests made at the insured person's request;
- Physicians' consultations and treatments, except for outpatient rehabilitation.

10. Vaccination

- Physicians' consultations on vaccination;
- Vaccines and vaccination selected by an insured person or appointed by a physician.

11. Eyeglasses and contact lenses

- Eyeglasses selection service;
- One pair of eyeglass lenses during the insurance year;
- Contact lenses.

12. Wellness services

- Physical education sessions;
- Kinesitherapy sessions;
- Water treatments;
- Manual therapy sessions;
- Massages.

13. Prenatal care

- Examinations of the pregnant, medical consultations, tests for pregnancy monitoring;
- Diagnosis and treatment of pregnancy complications;
- Childbirth care;
- Single or double ward.

14. Other medical services

- Services provided in health care institutions: physician's consultations, diagnostic tests, surgery, nursing, rehabilitation therapy, prophylaxis, vaccination;
- Medicines: medicinal products, dietary supplements, medical instruments, orthopaedic technical products;
- Eyeglasses and contact lenses, eyeglass frames, goggles, eyeglasses selection and production services, eyeglass lens care products (solutions for contact lenses and liquid cleaners for eyeglass lenses).
- Dental services: dental care, oral hygiene, prosthetics, implants, orthodontic treatment.
- Wellness services: physical education sessions, kinesitherapy sessions, water treatments, manual therapy sessions, massages.

Insured events (health insurance programs) and conditions of insurance benefits agreed between the policyholder and the insurer shall be specified in individual contract conditions.

Dr. Kęstutis Bagdonavičius
Chief Executive Officer

Ingrida Kirse
Member of the Board

Health Insurance rules No. 010 Annex 2

Pricelist of Additional Services of an Insurance Contract

Issuing an additional copy of the insurance policy	4 EUR
Issuing a duplicate of the insurance policy	4 EUR
Replacement of an insurance book (card) (when lost or damaged)	3 EUR

If payment for several services shall be made at a time, only the most expensive service shall be paid for.

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